IMPROVED QUALITY AND EXPANDED CHOICE: THE FUTURE OF MEDICARE

AN ADDRESS

BY

WILLIAM L. ROPER, M.D.
ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

HEALTHCARE FINANCIAL MANAGEMENT ASSOCIATION

WASHINGTON, D.C.
APRIL 23, 1987

*THIS IS THE BASIS OF THE ADMINISTRATOR'S ORAL PRESENTATION. IT SHOULD BE USED WITH THE UNDERSTANDING THAT SOME MATERIAL MAY BE ADDED OR OMITTED DURING DELIVERY.

Since coming to the Health Care Financing Administration almost a year ago, I have had three main goals for the agency and for our programs:

First, to maintain and enhance a high level of quality throughout the Medicare and Medicaid programs. As physicians, Secretary Bowen and I have no higher aim.

Second, to expand and extend competition and choice for both beneficiaries and providers, primarily through what we call the Private Health Plan Option.

Third, to promote greater efficiency in HCFA itself. I want HCFA to work better for the benefit of all concerned with health care -- consumers, providers, government, and taxpayers. Moreover, as we promote competition and the role of the private sector in health care, so I want HCFA to work with others as a fair business partner.

Today, there is a new focus on quality in a competitive health care system. Hospitals and health systems across the country are investing in quality, for they realize that consumers value quality in health care. This Administration believes that competition among health care providers can be an effective incentive for quality in health

care. Clearly the cornerstone of quality assurance is the professionalism of individual providers. But even in a more competitive system, government will still have a responsibility to monitor quality and take appropriate action to ensure quality.

Our concern for quality is manifested in many areas. For example, last December, we held a symposium on the significant policy issues in quality of care measurement. We got real help in making some important policy decisions.

Let me elaborate -- I think there is a pressing need to define more precisely what we mean by "quality." Insofar as possible, we need to develop much better measures of quality.

One issue vigorously discussed in our December quality symposium was how best to release information on the quality of care to the general public. If you believe, as I do, in a more competitive health care system, you must believe in giving consumers appropriate information on which they can base choices. Competition depends upon informed consumers.

Last year HCFA issued data on the mortality rates of hospitals, one very rough measure of quality under certain circumstances. That material was intended for the use of the PROs conducting review of care provided to Medicare patients, and we stated clearly that the lists did not necessarily indicate good or bad providers. We learned from the experience of last year that people like getting information about the quality of health care. And so we are working for release of data this year, after further consultation with affected parties, rather than waiting until the system is perfect.

To be clear, our purpose is to inform, not to inflame. We will continue working with interested groups to identify what data should be routinely released, and also what role the Federal government should play in a system to measure quality. Let me also say that I believe hospitals should be able to review any material released before it is released to the general public. It should not be sprung on you as a surprise. That was one strong recommendation we received at our December quality symposium, and I think it is a good one.

Moreover, we want to keep in sight our objective: how consumers and providers can best use this data to improve the quality of medical care. I believe doctors and hospitals should be in the forefront of the effort to develop effective quality measures and encourage the wide dissemination of this information -- another strong message at the December meeting. Finally, let me say that I agree that we need to devise other means of measuring quality. Mortality rates are just one piece of a large picture -- important, but not the whole story.

The public release of mortality rate data highlights another issue: the expanded role of Peer Review Organizations. Last year we held a series of meetings with consumers, providers, and PRO groups on improving the PRO program. Secretary Bowen later approved a PRO "action plan" which calls for several reforms of interest to hospitals. First, we are trying to reduce unnecessary review. We are undertaking a number of steps to improve the work of the PROs, their consistency, and how we manage them.

Let me mention one of our upcoming PRO activities. Congress has now required PROs to deny payment for substandard care. The very notion of calling something "substandard care" raises a problem of definition which we must address in our Notice of Proposed Rulemaking on the subject. While we endorse this provision, we want to make clear that it is not our policy to judge the PROs on the number of denial notices they issue. Our purpose is to ensure quality, not to provoke severe discipline. We seek to educate, not to punish.

But as I said earlier, there will always be a need, on occasion, for vigorous government action against poor quality providers. For example, we recently took action against a California hospital which had flagrantly "dumped" patients. This was entirely appropriate; we will not tolerate dumping of patients in the Medicare and Medicaid programs. Once the hospital took concrete steps to remedy the problem, we readmitted them to the program. So while we are willing to consider the measures a hospital takes to

solve a problem, we will not hesitate to use quick and strong action to assure both a high standard of care and complaince with the law.

My second objective at HCFA is the further development of what we now term the private health plan option. The private health plan option reflects four values that guide our approach to Medicare policy:

-- first, to reduce government's direct role in medical and pricing decisions;
-- second, to increase choices, both for beneficiaries and providers of care;
-- third, to promote competition among private organizations that deliver health care;
-- and finally, to sharpen the industry's incentives for efficiency.

We have already come a long way in meeting these objectives. In 1980, many said that there could not be competition in health care. Now, some say that they do not like competition, or at least that they are troubled by some of its effects.

We all need to work together to spread the word that competition in health care is just beginning, and that it can have positive effects on our health care system.

While the current PPS system has produced some good results, few have been fully pleased with the overall system. PPS is an administered price system, with all that entails. Providers rightly claim that it limits their freedom of operation. And we do not enjoy having to assume an ever greater regulatory role over the practice of medicine in this country -- that runs counter to our whole theory of the proper role of government.

The better alternative is the Private Health Plan Option, formerly called "capitation."

Let me be clear about our goals for this program. It has never been our intent to force Medicare beneficiaries into managed care plans. That is emphatically not our policy. Our policy is choice. No beneficiary will be forced to leave coverage under traditional Medicare for a private plan.

It is crucial to understand that we regard the private health plan option as a means to give Medicare beneficiaries and health care providers greater choice in health care. We think this greater choice will benefit all concerned with health care -- consumers, providers, and government.

We favor choice. We favor choice both between traditional Medicare and managed care and choice within the domain of managed care. For the future, we look forward to the proliferation of a wide variety of plans and options.

Our goal is not to support one particular type of private plan -- such as HMOs or CMPs -- but to maximize beneficiary choice.

This decentralization of decisionmaking in Medicare has important implications for health care providers. At the present time you have little choice about whether to participate in Medicare. Under such a decentralized system, you could use your good judgment with regard to each plan. And competition among various plans is an important guarantee of quality. At the moment, the system seems to work according to the "golden rule" -- those with the gold make the rules.

The President's proposed 1988 budget expands this approach to allow employment-based plans to assume responsibility for providing Medicare benefits to their retirees in exchange for a fixed government contribution. We hope to begin demonstration projects of these "Medicare-insured groups" this year.

The Medicare-insured group concept has attracted wide interest among employers and unions. Medicare-insured groups will permit employers to coordinate their

Medicare and supplemental benefits. And retirees can stay in the same plan that covered them during their working years.

As the MIG concept demonstrates, another premise of the PHPO is that our efforts are vitally linked to developments in the private sector itself. Medicare cannot lead the way to changes in managed care; it must follow them. We favor making available to Medicare beneficiaries the same variety of options available to people under age 65.

That is a real guarantee that the quality and level of service available to Medicare beneficiaries will equal that available to others. The Private Health Plan Option, then, furthers the goal of quality health care for older Americans.

We are about to implement an important new quality assurance mechanism for the PHPO -- quality review by PROs and other quality review organizations of HMOs and CMPs. This is an important step -- managed care will not succeed unless the American people are convinced that managed care is quality care.

Health care providers should not delude themselves about what is likely to happen under traditional fee-for-service Medicare. Fiscal constraints will continue to force limitations in the rise of expenses throughout the Medicare program. That is an economic and political fact.

Even so, we do intend to pay a fair level to managed care plans so that the private health plan option can be a viable business opportunity for providers. Our goal is to set up a choice between the private health plan option and traditional Medicare -- a fair market test. We do not intend to use the PHPO as simply a means to cut payments. Simply put, we can't afford to do that -- it would be counterproductive since the PHPO is voluntary for providers as well as consumers.

The final verdict is not yet in on the PHPO. We have only just begun to expand choices for beneficiaries and providers. Competition will sharpen the health care industry, as it has other industries. We see further increased competition in the future of health care in any event. Health care providers should plan now to devise new and effective strategies for this competitive environment.

Our policies emphasize competition and the role of the private sector. This works both ways: just as we promote competition, we hope we are very aware of the requirements of the marketplace, and we want you to be able to count on us as a fair business partner -- my third goal for HCFA.

Just as Medicare beneficiaries have the right to expect fair treatment and quality in the services they receive, so providers expect that we will be a fair business partner. We want to remove the unnecessary irritations that complicate our relationship and take us further away from our goal of providing health care of high quality.

As you well know, our health care system is changing rapidly. That is one powerful reason for giving more control to the private sector.

Before I address these other points directly, however, I would like to discuss the President's proposed budget for fiscal year 1988. I know many groups have been quite outspoken about the budget. I appreciate that point of view, but let me be equally plainspoken: The reason the proposed savings from Medicare look so large is because the budget baselines are so extraordinary high. We are not "savaging" the Medicare and Medicaid programs. Far from it -- we are improving the quality of these programs. Fiscal restraint is here to stay; we all need to deal with it constructively.

We look forward to full and free debate in the Congress on the budget. In the process, we need to put this budget in context. Spending for the Medicare and Medicaid programs represents 28 percent of the HHS budget and 10 percent of the entire Federal budget. This figure is projected to equal 2.1 percent of the Gross National Product in 1988 -- and not inappropriately, since the two programs serve 52 million Americans.

Total Medicare outlays in 1988, including the proposed regulatory and legislative changes, are estimated at $81.9 billion, 4.8% percent higher than the current 1987 estimate. Spending will thus increase faster than the estimated rate of general inflation for fiscal year 1988.

Let me mention one specific: In the budget, we propose to incorporate Medicare payment of hospital capital costs gradually into the Prospective Payment System at the level envisioned in last year's budget act. There will be a fixed payment encompassing both operating and capital costs. This change will expand the incentives for hospital efficiency already included in prospective payment.

We have consulted with many people on this issue, and we are continuing this consultative process with industry, the Congress, and others. Our draft regulatory proposal provides for a ten-year transition period for fixed plant costs and a two-year transition for moveable equipment. As specified by the 1986 Budget Act, total capital payments will equal those which would have been made under the cost reimbursement system, less 7 percent in fiscal year 1988 and 10 percent in fiscal year 1989.

We look forward to working with you on the details of this capital proposal, and on all other budget items. We need and we solicit a constructive working relationship with you.

An appropriate payment rate under PPS for hospitals is an important part of that relationship. The Administration is now considering revising the PPS update figure proposed in the President's budget. The new figure could reach as high as 2 percent, although we prefer to defer a final recommendation until nearer the beginning of the fiscal year, when

more recent data will be available to develop an equitable and realistic figure.

This possible change reflects our general policy towards PPS for the past two years. The PPS rate should be increased modestly, so as not to force dislocation in the hospital industry, but the Medicare program should continue to benefit from increased hospital efficiency which has resulted from PPS.

We favor gradually changing PPS rates rather than forcing dramatic reductions. I recognize that many hospitals face tight financial

pressures such as maintaining a qualified nursing staff and uncompensated care for non-Medicare patients. So in assessing an appropriate update factor for FY 1988, Congress should consider the varying effects of PPS on different types of hospitals in different regions. We will soon be submitting a report to Congress documenting these variations.

The future of American health care depends in large measure on the ability of private industry and government to work with health care providers, hospitals and physicians, and with consumers. The members of this organization have done good work in building these relationships.

I thank you for your past support. And though we may not agree on every issue in the future, our determination to work with you as a fair business partner is strong. That is a policy which reflects our belief in competition.

Then, let us use the benefits of competition to help bring about a better Medicare program and a better health care system. It is a goal well worthy of our determined efforts.

CMS LIBRARY
3 8095 00014125 5